Dr Jayadevan a/l Arayan & Anor v Sharon Simon (suing through her father and next friend Selvarajah Simon Rayan) & Ors

COURT OF APPEAL (KUALA LUMPUR) — CIVIL APPEAL NO W-04-71 OF 1996
SHAIK DAUD, SITI NORMA YAAKOB AND DENIS ONG JJCA
18 APRIL 2000

Civil Procedure *— Appeal — Fact, finding of — Interference by appellate court — Case depended mainly on finding of fact of trial court — Whether appellate court could allow appeal without giving reasons concerning finding of fact*

Tort *— Negligence — Professional negligence — Medical practitioner — Patient bled to death after child birth — Whether negligent in not storing blood for transfusion — Whether correct procedure for treatment was adopted and blood transfusion given on time*

The respondents sued the appellants in the sessions court alleging that the death of one Pearly Chia Cheen Choo ('the deceased') was caused by the negligence of both the appellants when she was admitted to the second appellant's medical centre for the delivery of her baby, ie the first respondent. After the first respondent was successfully delivered by the first appellant, the deceased started to bleed and the first appellant gave the deceased Hartman's solution and haemacel to maintain her blood pressure. In anticipation of a blood transfusion, arrangements were made for blood to be obtained from the Kuala Lumpur General Hospital Blood Bank. A transfusion was later given. The deceased bled to death and died as a result of post-partum haemorrhage. The principal allegation against the appellants was the failure of the medical centre to store blood during the delivery of the deceased's baby and consequently its failure to transfuse blood to the deceased on time. The appellants contended that the deceased was a low risk case and that there was no requirement for medical centres, such as the second appellant, to have a blood bank. Furthermore, there was an existing arrangement between the second appellant and the Kuala Lumpur General Hospital Blood Bank for any request for blood. The appellants also contended that they had adopted the correct procedure when they attended to the deceased's bleeding. The sessions court dismissed the suit but the High Court reversed the decision of the sessions court and found the second appellant medical centre to be ill-equipped to deal with the deceased's case. The appellants appealed.

Held, allowing the appeal with costs:

(1) This case depended mainly on finding of fact by the trial judge of the sessions court and it is trite law that an appellate court should be slow in disturbing findings of fact by a trial judge. Based on the finding of fact, the trial judge came to the conclusion that since the deceased was not a high risk patient, it was reasonable for the

first appellant not to foresee that any complication would arise when he attended to the deceased's delivery. The complication, if at all, came after the delivery when the deceased started bleeding. The trial judge therefore, concluded that on a balance of probability the court was satisfied that the respondent had not shown that the appellants were negligent in not storing blood for the deceased before the delivery (see pp 660G, 662B–C).

(2) The trial judge found that the line of treatment adopted by the first appellant was a correct one which was confirmed and supported by the witnesses and an authoritative medical text. Further, ten minutes later and while the Hartman's solution and haemacel were administered, the first appellant directed the nurse to get blood for possible transfusion. From this, the learned sessions court judge found that the first appellant had not been negligent and that there was no delay in getting blood from the blood bank (see pp 662H–663A).

(3) The respondents complained that the appellants failed to diagnose the cause of the bleeding and failed to take steps to stop the bleeding. On this issue, the trial judge critically considered the evidence of Dr Mehra, Dr S Das and the first appellant who attended to the deceased immediately upon the start of the bleeding and their actions were confirmed as being the correct course to manage and treat the deceased. Based on this, the trial judge came to the conclusion that the respondents' allegation had not been proven. On the totality of the evidence before the trial judge, there was no reason to interfere with the findings and decision. The High Court judge erred when he interfered with the findings of fact of the trial court, especially in the case when no reason whatsoever was given for arriving at such an opposing decision as that of the trial judge (see p 663B–D).

[Bahasa Malaysia summary

Responden-responden telah mendakwa perayu-perayu di mahkamah sesyen dengan mengatakan bahawa kematian seorang bernama Pearly Chia Cheen Choo ('si mati tersebut') telah diakibatkan oleh kecuaian kedua-dua perayu apabila beliau dimasukkan ke hospital perayu kedua untuk melahirkan anaknya, iaitu responden pertama. Selepas responden pertama berjaya dilahirkan dengan bantuan perayu pertama, si mati mulai mengalami pendarahan dan perayu pertama memberikan si mati larutan Hartman dan haemacel untuk mengekalkan tekanan darahnya. Dalam mengharapkan suatu transfusi darah, persediaan telah dibuat untuk mendapatkan bekalan darah daripada Tabung Darah Hospital Besar Kuala Lumpur. Suatu transfusi telah diberikan kemudian. Si mati mengalami pendarahan sehingga maut dan meninggal di atas akibat perdarahan post partum. Pengataan utama terhadap perayu-perayu adalah kegagalan pusat

perubatan untuk menyimpan bekalan darah semasa kelahiran bayi si mati dan dengan itu gagal untuk memberikan transfusi darah kepada si mati tepat pada masanya. Perayu-perayu menegaskan bahawa si mati adalah kes berisiko rendah dan tiada keperluan untuk pusat-pusat perubatan untuk menyediakan tabung darah. Selanjutnya, terdapat persetujuan sedia ada antara perayu kedua dan Tabung Darah Hospital Besar Kuala Lumpur untuk sebarang permintaan darah. Perayu-perayu menegaskan bahawa mereka telah menerima pakai prosedur yang betul apabila mereka merawat pendarahan si mati. Mahkamah sesyen menolak guaman tersebut tetapi Mahkamah Tinggi membatalkan keputusan mahkamah sesyen dan mendapati bahawa pusat perubatan perayu kedua adalah tidak bersedia untuk menghadapi kes si mati. Perayu-perayu telah merayu.

Diputuskan, membenarkan rayuan tersebut dengan kos:

(1) Sebahagian besar kes ini bergantung kepada penemuan fakta oleh hakim perbicaraan mahkamah sesyen dan adalah undang-undang yang tidak boleh disangkal bahawa mahkamah rayuan sepatutnya lambat di dalam menganggu penemuan-penemuan fakta hakim perbicaraan. Berdasarkan penemuan-penemuan fakta, hakim perbicaraan telah mencapai kesimpulan bahawa oleh kerana si mati bukanlah pesakit yang berisiko tinggi, adalah munasabah untuk perayu pertama untuk tidak menjangkakan sebarang komplikasi akan timbul apabila beliau menguruskan kelahiran anak si mati. Komplikasi tersebut jikalau ada sekalipun hanya datang selepas kelahiran apabila si mati mulai mengalami pendarahan. Hakim perbicaraan dengan itu, menyimpulkan bahawa di atas imbangan kebarangkalian mahkamah berpuas hati bahawa responden tidak menunjukkan bahawa perayu-perayu adalah cuai di dalam tidak menyimpan darah untuk si mati sebelum kelahiran tersebut (lihat ms 660G, 662B–C).

(2) Hakim perbicaraan mendapati bahawa cara rawatan yang diterima pakai oleh perayu pertama adalah betul yang disahkan dan disokong oleh saksi-saksi dan buku perubatan yang berautoriti. Selanjutnya, sepuluh minit kemudian dan sementara larutan Hartman dan haemacel diberikan, perayu pertama mengarahkan jururawat untuk mendapatkan darah untuk kemungkinan transfusi darah. Daripada ini, hakim mahkamah sesyen mendapati bahawa perayu pertama tidak cuai dan tiada kelengahan di dalam mendapatkan darah daripada Tabung Darah (lihat ms 662H–663A).

(3) Responden-responden telah mengadu bahawa perayu-perayu telah gagal dalam mendiagnosa akibat pendarahan tersebut dan gagal untuk mengambil langkah-langkah untuk menghentikan pendarahan tersebut. Berkenaan isu ini, hakim perbicaraan telah mempertimbangkan secara kritikal keterangan Dr Mehra, Dr S Das dan perayu pertama yang merawat si mati secara terus

sejak pendarahan bermula dan tindakan-tindakan mereka disahkan sebagai cara yang betul untuk mengurus dan merawat si mati. Berdasarkan ini, hakim perbicaraan telah mencapai kesimpulan bahawa pengataan-pengataan responden belum lagi dibuktikan. Atas keterangan secara menyeluruh di hadapan hakim perbicaraan, tiada sebab untuk menganggu penemuan-penemuan dan keputusannya. Hakim Mahkamah Tinggi silap apabila beliau menganggu penemuan fakta mahkamah perbicaraan, terutamanya di dalam kes di mana tiada sebab apa sekalipun telah diberikan di dalam mencapai keputusan bertentangan yang sedemikian seperti yang dibuat hakim perbicaraan (lihat ms 663B–D).]

Notes

For cases on finding of fact, see 2(1) *Mallal's Digest* (4th Ed, 1998 Reissue) paras 531–608.

For cases on professional negligence, see 12 *Mallal's Digest* (4th Ed, 1996 Reissue) paras 559–590.

Appeal from: Civil Appeal No R2–12–5 of 1995 (High Court, Kuala Lumpur)

PS Ranjan (*MS Dhillon* with him) (*PS Ranjan & Co*) for the appellants.
PM Mahalingam (*TK Joshi* with him) (*Radzi Sheikh Ahmad Peri & Saini*) for the respondents.

Shaik Daud JCA (delivering judgment of the court): This case was originally heard in the sessions court which gave judgment to the appellant but on appeal, the High Court reversed the decision of the sessions court and entered judgment for the respondents. In considering this appeal, we regret to say that we could not rely on the judgment of the learned judge of the High Court which is rather short, sketchy and without condescending to reasons and detailed analysis of the factual evidence as found and accepted by the learned sessions court judge. The trial before the learned sessions court judge took some 26 days with four days for submission by both sides. This case depends mainly on finding of facts by the sessions court judge and it is trite law that an appellate court should be slow in disturbing findings of fact by a trial judge. This, however, does not mean that an appellate court is prohibited from analyzing those findings of fact and come to a different conclusion but in doing so, the appellate court ought to give reasons therefore. Sad to say in the present appeal we find that the learned judge failed to give any reasons whatsoever for rejecting the findings of fact by the sessions court judge. In the light of this it is now open for us to evaluate the evidence as found by the learned sessions court judge.

The respondents had sued both the appellants in the sessions court alleging that the death of one Pearly Chia Cheen Choo ('the deceased') was caused by the negligence of both the appellants in managing her when she was admitted to the second appellant's medical centre. The principal allegation against the appellants was the failure of the medical centre to

store blood when undertaking the delivery of the deceased's baby on 19 June 1988, and consequently failed to transfuse blood to her on time.

The evidence shows that the deceased was admitted into the second appellant's medical centre on 18 June 1988, for the delivery of her baby ie the first respondent. The first respondent was successfully delivered by the first appellant at 4.50 pm the same day. Later, at the request of a nurse at the centre, the deceased's husband, the second respondent, was requested to go to the blood bank at the Kuala Lumpur General Hospital to take delivery of blood which was required by the deceased. After taking delivery of the blood, he returned to the centre with the blood but was informed that his wife had passed away. The record shows that the deceased died at 7.30 pm. Post mortem evidence given by the pathologist Dr Abdul Karim shows that the deceased died as a result of post-partum haemorrhage, in other words, she bled to death.

After minutely evaluating the evidence of all the witnesses in detail including that of the first appellant and the medical records of the deceased, the learned sessions court judge rightly came to the conclusion that the first issue she had to decide was whether the appellants, who were the defendants in the lower court, were negligent in not storing blood at the second appellant's premises where the deceased was admitted for delivery. The respondents relied on the evidence of one Dr Amrik Singh a general practitioner who categorically stated that blood must be stored, as this practice was adhered to by government hospitals where he was posted before. This view was opposed by the first appellant himself, who testified that the deceased was a low risk case and that there was no requirement that medical centres, such as the second appellant, should have a blood bank. This was confirmed by one Dr S Das, the medical superintendent and anaesthetist of the second appellant who also attended to the deceased. Furthermore, there was an existing arrangement between the second appellant and the Kuala Lumpur General Hospital Blood Bank as regards any request for blood. In this case, when he noticed the deceased was bleeding, the first appellant gave her Hartman's solution and haemacel, so as to maintain her blood pressure and at the same time in anticipation of a blood transfusion asked the nurse to get blood from the blood bank of the Kuala Lumpur General Hospital. Later blood transfusion was in fact given. The learned sessions court judge also considered the evidence of the expert witness one Dr M Kanagalingam who gave his opinion based on the antenatal report that there was no evidence before the delivery to show that the deceased was likely to have a bleeding problem and was not a high risk patient. Dr Kanagalingam also disagreed with Dr Amrik Singh that it was the practice to order blood before any delivery case. The learned sessions court judge accepted the expert evidence of Dr Kanagalingam as more probable than that of Dr Amrik Singh and she did give her reasons for it saying that his opinion was more probable based on his vast experience as a consultant obstetrician and gynaecologist both in the government service as well as in private practice and that he based his opinion on various medical literatures. The learned sessions court judge weighed the evidence of Dr Amrik Singh and that of Dr M Kanagalingam, she accepted

Dr M Kanagalingam's evidence as being more probable. She added further that to accept Dr Amrik Singh's evidence that blood must be stored before any delivery would result in an absurd situation when one bears in mind that deliveries are also conducted by midwives in houses of the mothers where blood would not be stored before such deliveries.

On the totality of the evidence, she could not rely on the evidence of Dr Amrik Singh. She came to the conclusion that since the deceased was not a high risk patient, it was reasonable for the first appellant not to foresee that any complication would arise when he attended to the deceased's delivery. The complication, if at all, came after the delivery when the deceased started bleeding. She therefore, concluded that on a balance of probability she was satisfied that the respondent had not shown that the appellants were negligent in not storing blood for the deceased before the delivery.

On assessing the evidence in their totality, we find no reason to disagree with this finding. We find that the learned sessions court judge had minutely considered in detail all the evidence before arriving at the finding, and we agree with her finding. We find that the finding of the learned judge of the High Court that the 'respondent medical centre had been ill-equipped to deal with the deceased's case' is unfounded and baseless.

The second head of negligence which the learned sessions court judge considered was whether there was failure to exercise reasonable skill in the care and management of the deceased before and after the surgery. According to the respondents, the appellant's negligence before delivery was in not storing blood before the delivery. This has in fact been answered above and we need not add anymore. As for the alleged negligence after delivery, it was alleged that the first appellant failed to give blood transfusion as soon as possible. It cannot be denied that the expression 'as soon as possible' is rather relative. It must depend on the facts and circumstances of each particular case.

Again on this issue the respondents relied heavily on the evidence of Dr Amrik Singh who opined that the first appellant ought to give the deceased blood transfusion immediately upon seeing that the deceased was bleeding and that her pressure could not be recorded. According to the evidence of the first appellant at 5.25 pm when he noticed that the deceased was pale, her pressure was unrecordable and there was bleeding from her uterus, he gave Hartman's solution and haemacel to her to improve and maintain her blood circulation. This line of treatment according to Dr M Kanagalingam was a correct one for the first appellant to take in the circumstances. He was also of the opinion that at this point of time, there was no need for a blood transfusion. The learned sessions court judge found that the line of treatment adopted by the first appellant was not only confirmed and supported by Dr M Kanagalingam, but had also been expressed as the correct procedure to be adopted when reference was made to the extract from the textbook *Obstetrics* by Sir Alec Turnbull & Geoffrey Chamberlain. Dr Amrik Singh also agreed with this when he was cross-examined. Further it is also in evidence that ten minutes later and while the

Hartman's solution and haemacel were being administered, the first appellant had directed the nurse to get blood for possible transfusion. From this the learned sessions court judge found that the first appellant had not been negligent and that there was no delay in getting blood from the blood bank.

The respondents also complained that the appellants failed to diagnose the cause of the bleeding and failed to take steps to stop the bleeding. On this issue the learned sessions court judge critically considered the evidence of one Dr Mehra and Dr S Das and the first appellant who attended to the deceased immediately upon the start of the bleeding. Their actions were confirmed by Dr M Kanagalingam as being the correct course to manage and treat the deceased. Based on this the learned sessions court judge rightly came to the conclusion that the respondents' allegation had not been proven. On the totality of the evidence before the learned sessions court judge, we find no reason to interfere with her findings and decision. The learned High Court judge erred when he interfered with the findings of fact of the trial court, especially in the case when no reason whatsoever was given for arriving at such an opposing decision as that of the sessions court judge. We find the learned sessions court judge has given a well reasoned judgment and we have no reason to disagree with her. In the circumstances we allow the appeal with costs here and below. We set aside the decision of the learned judge of the High Court, restore the decision of the learned sessions court judge, and order that the deposit to be refunded to the appellants.

Appeal allowed with costs.

Reported by Chin En Tek